THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-0701.M2

NOTICE OF INDEPENDENT REVIEW DECISION

August 9, 2002

RE: MDR Tracking #: M2-02-0732-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in anesthesiology which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 55 year old male sustained a work related injury on ___ while lifting a piece of metal. He experienced pain to his lumbar spine and a laceration of the left finger. An MRI of the left hand performed on 11/10/00 revealed soft tissue swelling. X-rays of the thoracic spine performed on 12/05/00 were unremarkable. The patient underwent an EMG on 12/21/00 and MRI's of the lumbar, sacral and cervical spine on 01/12/01. Conservative treatment has included physical therapy, epidural steroid injections, and massage therapy.

The treating physician has recommended that the patient undergo a lumbar discogram with post CT scan.

Requested Service(s)

Lumbar discogram with post CT scan

Decision
It is determined that the lumbar discogram with post CT scan is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

This patient has chronic low back pain without radicular symptoms and has not responded to conservative treatment including epidural steroid injections, and time. The medical record documentation indicates that the precise location of the patient's pain still remains unknown. Discogram can not only be of a positive benefit (that is to be used to define treatment to the specific offending disc) but can also be a negative benefit (to identify patients with multi-level symptomatic pathology and therefore eliminate non-indicated surgical treatment possibilities). Performing a CT/discogram on this patient may avoid future ill-advised treatment if he is found to have symptomatic disc disease at multiple levels. The post CT scan has been recommended by the radiologist and the treating physician after reviewing the results of an MRI of 01/12/01. It may be useful to better identify bone spurs seen on the MRI and will add more specificity to the discogram. Therefore, a lumbar discogram with post CT scan is medically necessary.

Reference: Sachs, Vanharanta, Spivy: "CT/discography in low back pain disorders". Spine 12:287-294, 1987.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (10) days of your receipt of this decision (20 Tex. Admin. Code 142.5 (c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,